State: Missouri

DIRECT PAYMENTS

(1) All recipients whose eligibility for Medicaid benefits is denied and whose eligibility is subsequently established as a result of an agency hearing decision, a court decision based on an agency hearing decision, or any other final agency decision rendered on or after January 1, 1986, may be reimbursed by the Medicaid agency for Medicaid services paid by the recipients to providers between the date of the agency decision denying their eligibility and the date of the agency or court decision establishing their eligibility for Medicaid benefits.

(A) Payments to a recipient will be made only for medical services which were covered services at the time provided in accordance with Medicaid program benefits, limitations and requirements applicable to the services or the recipient as of the date provided except that prior authorization requirements will not apply.

(B) Payments may be made for services of either an enrolled Medicaid provider or for providers who do not participate in Medicaid.

(C) Payments to a recipient will be limited to the lesser of the Medicaid allowable amount for the covered item or service as of the date provided or the aggregate amount paid by the recipient for the covered item or service.

(D) Any medical expenses paid by the recipient which are for the purpose of meeting that recipient's spenddown obligation are not payable except for those services deemed to have been provided on the first date of spenddown eligibility.

(E) All third party resource benefits received by the recipient for Medicaid-covered services must be applied against the lesser of the Medicaid allowable amount for the covered item or service as of the date provided or the aggregate amount paid by the recipient for the covered item or service. No payment shall be made to the recipient until all third party resource benefits have been exhausted as would have been applicable to recipients receiving Medicaid. For purposes of this regulation, neither the provider nor the recipient shall be required to exhaust all third party resources in those situations where the provider or the recipient elect not to pursue contingent liability from a third party tortfeasor. Both the provider and the recipient have an affirmative duty to report the existence of contingent liability to the Division of Medical Services and the recipient has the duty to cooperate with the Division of Medical Services if the division elects to pursue the contingent liability.

(F) As evidenced by the Medicaid agency's date of receipt, the recipient or person legally responsible will have one (1) year from the date of the final agency or court decision establishing eligibility to submit all written requests for recipient payment to the Medicaid agency with sufficient documentation to determine the appropriate reimbursement amount under the applicable provisions of subsections (1) (A), (C) and (E) for the Medicaid-covered items or services paid for by the recipient.